Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration
and
Aging and Disability Services Administration

Adult Day Health

Billing Instructions

(WAC 388-71-0702 through 0776)

About this publication

This publication supersedes all previous Adult Day Health Billing Instructions.

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Note: The effective date and publication date for any particular page of this document may be found at the bottom of the page.

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Important Contacts

A provider may use MAA's toll-free lines for questions regarding MAA's programs. However MAA's response is based solely on the information provided to the representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern MAA's programs. [WAC 388-502-0020(2)]

How do I obtain information on becoming a DSHS provider, submitting a change of address or ownership, or to ask questions about the status of a provider application?

Contact Provider Enrollment:
http://maa.dshs.wa.gov/provrel/ **or**
(866) 545-0544 (toll free)

Where do I send my claims?

Electronic Claims:
Providers who would like to access the *free* WAMedWeb application can enroll now by contacting ACS EDI Gateway via telephone at (800) 833-2051 (toll free) or visit https://wamedweb.acs-inc.com/wa/general/home.do

Hardcopy Claims:
Division of Program Support
PO Box 9247
Olympia WA 98507-9247

How can I obtain copies of billing instructions or numbered memoranda?

To **view and download**, visit:
http://maa.dshs.wa.gov and select *Billing Instructions/Numbered Memoranda*

To **have a hard copy sent** to you, visit:
http://www.prt.wa.gov/ and select *General Store*

Who do I contact if I have questions regarding…

Adult Day Health or Adult Day Care?

Aging and Disability Services Admin.
(360) 725-2562

Home Health and Hospice?

Medical Assistance Administration
(360) 725-1582 or (360) 725-1570

Long-Term Care Needs?

Home & Community Services Office phone numbers are available in the front of local telephone books or call:
State Reception Line (800) 422-3263 (toll free) and ask for the local HCS number

Policy, payments, denials, or general questions regarding claims processing, or Healthy Options?

Contact Provider Relations:
http://maa.dshs.wa.gov/provrel/ **or**
(800) 562-6188 (toll free)

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136 (toll free)

Definitions

This section defines terms, abbreviations, and acronyms used in this billing instruction that relate to the Medical Assistance Program.

Adult Day Services - A community-based program designed to meet the needs of adults with impairments through individual plans of care. This type of structured, comprehensive, nonresidential program provides a variety of health, social, and related support services in a protective setting. By supporting families and caregivers, an Adult Day Services program enables the person to live in the community. An Adult Day Services program assesses the needs of the persons served and offers services to meet those needs. The persons served attend on a planned basis. "Adult Day Services" is a generic term referring to Adult Day Care and Adult Day Health services. [WAC 388-71-0702]

Adult Day Care - Supervised daytime program providing core services as defined under WAC 388-71-0704(2). Core services are appropriate for adults with medical or disabling conditions that do not require the intervention or services of a registered nurse or licensed rehabilitative therapist acting under the supervision of the client's physician. [WAC 388-71-0704 (1)]

Adult Day Health (ADH) - A supervised daytime program providing skilled nursing and rehabilitative therapy services in addition to core services outlined in WAC 388-71-0704. Adult Day Health services are only appropriate for adults with medical or disabling conditions that require the intervention or services of a registered nurse or licensed therapist acting under the supervision of the client's physician. [WAC 388-71-0706 (1)]

Aging and Disability Services Administration (ADSA) - As part of the Washington State Department of Social and Health Services, ADSA provides a broad range of social and health services to adult and older persons living in the community and in residential care settings. These services are designed to establish and maintain a comprehensive and coordinated service delivery system that enables persons served to achieve the maximum degree of independence and dignity possible.

Client - An individual who has been determined eligible to receive medical or health care services under any department program.

Code of Federal Regulations (CFR) - Rules adopted by the federal government.

Community Options Program Entry System (COPES) - A Medicaid-waivered program that provides a client who has been functionally assessed as in need of nursing facility care with the option to receive services at home or in an alternate living arrangement.

Community Services Office (CSO) - An office of the Department's Economic Services Administration that administers social and health services at the community level. [WAC 388-500-0005]

Contracting Process – The process by which the Department, or an Area Agency on Aging (or other Department designee) as authorized by the Department, must determine that the Adult Day Care or Adult Day Health center meets the applicable Adult Day Care or day health requirements and any additional requirements for contracting with the Area Agency on Aging through a COPES contract or with the department through a Medicaid provider contract. If a center is contracting for both day care and day health, requirements of both adult day services must be met. [WAC 388-71-0724 (1)]

Core Provider Agreement - The basic contract between MAA and an entity providing services to eligible clients. The core provider agreement outlines and defines terms of participation in medical assistance programs.

Department - The state Department of Social and Health Services.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Health Care Payment and Remittance Advice - The standard X-12 transaction, number 835, implemented as part of the federal Health Insurance Portability and Accountability Act (HIPAA). The 835 is the HIPAA alternative to the Remittance and Status Report (RA). It is intended for provider use in reconciling claims.

Intake Evaluation - A written evaluation of a client's skilled and core service needs. [WAC 388-71-0722 (1)]

Maximum Allowable - The maximum dollar amount MAA may reimburse a provider for specific services, supplies, or equipment.

Medicaid - The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) Programs.

Medical Assistance Administration (MAA) - The unit within the Department of Social and Health Services authorized to administer the Title XIX Medicaid and the state-funded medical care programs. [WAC 388-500-0005]

Medically Necessary - a term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this program, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Patient Identification Code (PIC) - An alphanumeric code assigned to each Medical Assistance client consisting of:

a) First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters or characters (dashes, apostrophes) of the last name (and spaces if the name is fewer than five letters).
d) Alpha or numeric character (tiebreaker).

Negotiated Care Plan—Adult Day Health— The plan of care developed by the Adult Day Health center to meet the individual needs of a client per the requirements of WAC 388-71-0772.

Primary care case management (PCCM) - The health care management activities of a provider that contracts with the department to provide primary health care services and to arrange and coordinate other preventive, specialty, and ancillary health services. [WAC 388-538-050]

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement with the department to furnish medical care and goods and/or services to clients; and
- Is eligible to receive payment from the department. [WAC 388-500-0005]

Provider Number – An identification number issued to providers who have a signed contract(s) with MAA.

Remittance and Status Report (RA) - A report produced by the Medicaid Management Information System (MMIS), MAA's claims processing system, that provides detailed information concerning submitted claims and other financial transactions. [See **Health Care Payment and Remittance Advice**.]

Revised Code of Washington (RCW) - Washington State laws.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client. [WAC 388-500-0005]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. [WAC 388-500-0005]

Usual and Customary Fee – The fee that the provider typically charges the general public for provision of a product or service.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

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About Adult Day Health

What is Adult Day Health (ADH)?

[Refer to WAC 388-71-0706]

ADH is a supervised daytime program providing skilled nursing services, skilled therapy services, psychological and counseling services, and core services. ADH services are only appropriate for adults with medical or disabling conditions that require the intervention or services of a registered nurse or licensed rehabilitative therapist acting under the supervision of the client's physician. Department-contracted ADH centers must bill MAA for ADH services.

What services must ADH centers provide?

[Refer to WAC 388-71-0704 and 388-71-0706]

DSHS reimburses contracted ADH centers that offer and provide **all** of the following services on site:

Skilled Nursing Services

- Skilled nursing services exceeding routine health monitoring with nurse consultation;

Skilled Therapy Services

- At least one of the following skilled therapy services:

    a. Physical therapy;
    b. Occupational therapy;
    c. Speech-language pathology; or
    d. Audiology.

Psychological and Counseling Services

- Psychological or counseling services, including:

    a. Assessing dementia, abuse or neglect, alcohol or drug abuse, and need for psycho-social therapy;
    b. Making appropriate referrals; and
    c. Providing brief, intermittent supportive counseling.

Core Services

- **Personal care services** including:

  a. Ambulation;
  b. Body care;
  c. Eating;
  d. Positioning;
  e. Self-medication;
  f. Transfer;
  g. Toileting;
  h. Personal hygiene at a level that ensures client safety and comfort while in attendance at the program; and
  i. Bathing at a level that ensures client safety and comfort while in attendance at the program.

- **Social services** on a consultation basis, which may include:

  a. Referrals to other providers for services not within the scope of the program requirements;
  b. Caregiver support and education; or
  c. Assistance with coping skills.

- **Routine health monitoring** with consultation from a registered nurse, acting within his or her scope of practice, with or without a physician's order. Examples include:

  a. Obtaining baseline and routine monitoring information on a client's health status, such as vital signs, weight, and dietary needs;
  b. General health education such as providing information about nutrition, illnesses, and preventive care;
  c. Communicating changes in the client's health status to the client's caregiver;
  d. Updating of the client's medical record (as needed, but at least annually); or
  e. Assistance with coordination of health services provided outside of the program requirements.

- **General therapeutic activities** that an unlicensed or licensed person can provide with or without a physician's order. These services are planned and provided as an integral part of the client's plan of care and are based on the client's abilities, interests, and goals. Examples include:

  a. Recreational activities;
  b. Diversionary activities;
  c. Relaxation therapy;
  d. Cognitive stimulation; or
  e. Group range of motion or conditioning exercises.

- **General health education** that an unlicensed person or licensed person can provide with or without a physician's order, including but not limited to topics such as:

  a. Nutrition;
  b. Stress management;
  c. Disease management skills; and
  d. Preventive care.

- **Nutritional meals and snacks** each four-hour period, provided at regular times which are comparable to normal meal times, including a modified diet if needed and within the scope of the program.

- **Supervision and/or protection for clients** who require supervision or protection for their safety.

- Assistance with **arranging transportation** to and from the program.

- **First aid** and provisions for obtaining or providing care in an emergency.

> ☞ **Note:** Adult day services programs offering only core services are considered Adult Day Care and are billed to the local Area Agencies on Aging (AAA) under the Community Options Program Entry System (COPES) contract.

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Client Eligibility

Who is eligible to receive Adult Day Health (ADH) services?

[Refer to WAC 388-71-0710 (1)]

DSHS clients are considered eligible for ADH services if they meet **all** of the following criteria according to the DSHS case manager's assessment and determination:

1. Are 18 years of age or older; and

2. Present a DSHS Medical ID Card with one of the following medical identifiers:

Medical Program Identifier	Medical Program
CNP	Categorically Needy Program including: √ General Assistance – Expedited (GA-X) - Disability determination pending
CNP-QMB	Categorically Needy Qualified Medicare Beneficiaries (CNP-QMB)
General Assistance	Alcohol and Drug Addiction Treatment and Support Act (ADATSA)

3. Are assessed as having an unmet need for skilled nursing or skilled rehabilitative therapy and:

a. Are at risk for deteriorating health, deteriorating functional ability, or institutionalization;

b. Have a chronic or acute health condition that the client is not able to safely manage due to a cognitive, physical, or other functional impairment;

c. There is a reasonable expectation that services will improve, restore or maintain the client's health status, or in the case of a progressive disabling condition, will either restore or slow the decline of the client's health and functional status or ease related pain and suffering.

4. Have needs for personal care or other core services, whether or not those needs are otherwise met.

Can clients who are enrolled in managed care receive ADH services?

Clients who are enrolled in an MAA managed care plan and meet the eligibility criteria on page B.1 may receive ADH services not covered by their managed care plan. The ADH provider must submit claims directly to MAA through the fee-for-service process.

Clients who are enrolled in an MAA managed care plan should have a Health Maintenance Organization (HMO) identifier in the HMO column of their Medical ID cards.

Can clients who receive home health, hospice, or private duty nursing services also receive ADH services?

No. Clients may not duplicate services. Any unusual situations require prior approval from the ADH Program Manager, as well as the Home Health, Hospice, or Private Duty Nursing Program Manager.

Note: MAA does not reimburse for *Adult Day Care* services. These are waivered services provided through contracts with local Area Agencies on Aging.

How are clients notified of their right to make their own health care decisions?

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, ADH providers, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all clients or their representatives** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

Coverage

When does DSHS cover Adult Day Health (ADH) services?

[Refer to WAC 388-71-0724(1)]

The department covers ADH services when the following criteria are met:

- The ADH center is contracted through the DSHS contracting process and meets the applicable ADH provider requirements (see pages D.1 – D.3).
- The ADH provider directly provides the services and meets service requirements set by the Aging and Disability Services Administration.
- The client receives skilled nursing services and/or skilled rehabilitative services each day of attendance.

What skilled nursing services does DSHS cover?

[Refer to WAC 388-71-0712]

DSHS covers medically necessary skilled nursing services. Medically necessary skilled nursing services may include:

1. **Care and assessment of an unstable or unpredictable medical condition**, with time limited, measurable treatment goals, requiring frequent intervention by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse;
2. **Evaluation and management of the care plan** when unstable medical conditions or complications require complex, non-skilled care and skilled nurse oversight to ensure that the non-skilled care is achieving its purpose;

3. **Time-limited training** by licensed nursing staff to teach the client and/or the client's caregiver self-care for newly diagnosed, acute, or episodic medical conditions that require the skills of a licensed nurse to teach, and that will optimize client function, as illustrated by the following examples:

- Self administration of an injection;
- Pre-filling insulin syringes;
- Irrigating a catheter;
- Caring for a colostomy or urostomy;
- Wound dressing changes or aseptic technique; or
- Disease self-management.

4. **Skilled interventions** provided directly by a licensed nurse such as:

- Inserting or irrigating a catheter;
- Administering medications or oxygen;
- Administering and managing infusion therapy; or
- Treating decubitis ulcers, or other types of wound care.

Note: Medically necessary skilled nursing services, by way of example, do **not** include:

- Reminding or coaching the client;
- Monitoring of a medical condition that does not require frequent skilled nursing intervention or a change in physician treatment orders, or where there is no reasonable expectation that skilled services will maintain, improve, or slow the effect of a progressive disabling condition on the pain, health, or functioning of a client;
- Medication assistance when the client is capable of self-administration or is having this need met through paid or unpaid caregivers;
- Evaluation and management of the care plan when the complexity of care to be provided by non-skilled persons does not require skilled nurse oversight beyond routine health monitoring;
- Continued training by nursing staff to teach self-care for newly diagnosed, acute, or episodic medical conditions when it is apparent that the training should have achieved its purpose, or that the client is unwilling or unable to be trained;
- Core services that can be provided by an Adult Day Care center, such as routine health monitoring, general health education, or general therapeutic activities; or
- Group therapy or training where three or more clients are being simultaneously treated or trained by the nurse.

What rehabilitative services does DSHS cover?

[Refer to WAC 388-71-0714]

Physical Therapy

DSHS covers medically necessary **physical therapy services**. Medically necessary physical therapy services may include:

1. **Assessing baseline** mobility level, strength, range of motion, endurance, balance, and ability to transfer;

2. **Individual and group treatment** to relieve pain or develop, restore, or maintain functioning, with individualized and measurable client treatment goals;

3. **Establishing a maintenance or restorative program** with measurable treatment goals, and providing written and oral instruction to the client, caregivers, or program staff as needed to assist the client in implementing the program;

4. **Training the client or the client's caregivers** in the use of supportive, adaptive equipment or assistive devices;

5. **Evaluating and managing the care plan** when medical conditions or complications require complex non-skilled care and skilled therapist oversight to ensure that the non-skilled care is achieving its purpose; or

6. **Providing other medically necessary services** that can only be provided by or under the direct or indirect supervision of a physical therapist acting within his or her scope of practice.

Occupational Therapy

MAA covers medically necessary **occupational therapy services**. Medically necessary occupational therapy services may include:

1. **Administering a basic evaluation** to determine baseline level of functioning, ability to transfer, range of motion, balance, strength, coordination, activities of daily living and cognitive-perceptual functioning;

2. **Teaching and training the client, caregivers, or program staff** in the use of therapeutic, creative, and self care activities to improve or maintain the client's capacity for self-care and independence, and to increase the range of motion, strength and coordination;

3. **Individual and group treatment** to develop, restore, or maintain functioning with individualized and measurable client treatment goals;

4. **Training the client or the client's caregivers** in the use of supportive, adaptive equipment or assistive devices;

5. **Evaluating and managing the care plan** when medical conditions or complications require complex non-skilled care and skilled therapist oversight to ensure that the non-skilled care is achieving its purpose; or

6. **Providing other medically necessary services** that can only be provided by or under the direct or indirect supervision of an occupational therapist acting within his or her scope of practice.

Speech/Audiology

MAA covers medically necessary **speech-language pathology or audiology services**. Medically necessary speech-language pathology or audiology services may include:

1. **Assessing baseline** level of speech, swallowing, auditory, or communication disorders;

2. **Establishing a treatment program** to improve speech, swallowing, auditory, or communication disorders;

3. **Providing speech therapy procedures** that include auditory comprehension tasks, visual and/or reading comprehensive tasks, language intelligibility tasks, training involving the use of alternative communication devices, or swallowing treatment;

4. **Training the client or the client's caregivers** in methods to assist the client in improving speech, communication, or swallowing disorders;

5. **Evaluation and management of the care plan** when medical conditions or complications require complex non-skilled care and skilled therapist oversight to ensure that non-skilled care is achieving its purpose; or

6. **Providing other medically necessary services** that can only be provided by or under the direct or indirect supervision of a speech-language pathology or audiology therapist acting within his or her scope of practice.

Note: Medically necessary skilled rehabilitative therapy services, by way of example, do **not** include:

- Reminding or coaching the client in tasks that are not essential to the skilled therapy or intervention in the client's service plan;
- Monitoring a medical condition that does not require frequent skilled therapist intervention or a change in physician treatment orders, or where there is no reasonable expectation that skilled services will maintain, improve, or slow the effect of a progressive disabling condition on the pain, health, or functioning of a client;
- Massage therapy;
- Evaluating and managing the care plan when the complexity of the care to be provided by non-skilled persons does not require the skills of a licensed therapist for oversight;
- Continued training by therapy staff to teach self-care for newly diagnosed, acute, or episodic medical conditions when it is apparent that the training should have achieved its purpose or that the client is unwilling or unable to be trained;
- Core services that can be provided by an Adult Day Care center, such as routine health monitoring, general health education, or general therapeutic activities; or
- Group therapy or training where the ratio of licensed therapists and assisting program staff to clients is inadequate to ensure that:
  a. The group activity contributes to the individual client's planned therapy goals; and
  b. The complexity of the individual client's need can be met

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Provider Requirements

Who can provide Adult Day Health (ADH) services?

[Refer to WAC 388-71-0738(2)]

ADH centers that meet all of the following criteria are eligible to bill MAA:

- The center has been authorized by the local Area Agency on Aging (AAA);
- The center is approved by Aging and Disability Services Administration (ADSA);
- The center has signed a Core Provider Agreement with MAA and received a provider number;
- The center provides a structured program for participants at least four hours a day; and
- The center operates at least three days a week.

Does an ADH center need authorization before providing services to an eligible client? [Refer to WAC 388-71-0720, 388-71-0722]

Yes. A DSHS (or a DSHS-authorized) case manager must assess a client and determine client eligibility and need for ADH. The case manager then refers the client to an ADH provider for services and provides appropriate authorization for ADH services.

- ADH centers must have written case manager authorization to receive reimbursement from MAA for ADH services.
- For a case manager to authorize an ADH center to be reimbursed for ADH services, the case manager follows specific requirements related to timelines, care planning, orders, etc.

What policies and procedures must an ADH center document? [Refer to WAC 888-71-0742]

1. ADH center policies must define admission criteria, discharge criteria, Health Insurance Portability and Accountability Act (HIPAA) policies, medication policy, participant rights and responsibilities, fee schedule, confidentiality, and grievance procedures.

2. The center must comply with all applicable nondiscrimination laws, including but not limited to age, race, color, gender, religion, national origin, creed, marital status, Vietnam era or disabled veteran's status, or sensory, physical, or mental handicap.

3. A participant bill of rights describing the client's rights and responsibilities must be developed, posted, distributed to, and explained to participants, families, staff, and volunteers. Participants will be provided the bill of rights in the language understood by the individual upon request.

4. The center must have an advance directive policy as required by the Patient Self Determination Act of 1990 (see 42 C.F.R. § 489.102 and chapter 70.122 RCW).

5. Discharge policies must include specific criteria that establish when the client is no longer eligible for services and under what circumstances the participant may be discharged for other factors. Unless the discharge is initiated by the client's department or authorized case manager, the center must notify the client, client representative if applicable, and case manager in writing of the specific reasons for the discharge. The center must also provide the client with adequate information about appeal and hearing rights. Discharge may occur due to client choice, other criteria as defined in the center's policy such as standards of conduct or inappropriate behavior, or changes in circumstances making the client ineligible for services.

6. Incident report policies must include investigation and reporting of any neglect, abuse, exploitation, accident, or incident jeopardizing or affecting a client's health or safety. The policy must include how the center will determine the circumstances of the event, restrictions on staff or clients during the investigation, how similar future situations will be prevented or decreased, and the location of incident reports. The center must keep a log of all reported incidents, participant grievances, complaints, and outcomes.

What must an ADH center do when a client has a break in service? [Refer to WAC 388-71-0722 (8) and WAC 388-71-0724 (8)]

- The ADH center must report changes in a client's condition or unanticipated absences of more than three consecutive days of scheduled service to the client's case manager within one week. Unanticipated absences, for example, may include absences due to client illness or injury. The case manager may follow up with the client and determine if any updates to the assessment, service plan, and service authorization are needed.

- The ADH center must review each service in the negotiated care plan every 90 days or more often if the client's condition changes or if the client is reassessed for eligibility after a break in service of more than 30 days.

- The ADH center may **not** initiate or bill for a new intake evaluation when a client returns after a break in service.

Who handles transportation issues?

[Refer to WAC 388-71-0724(10) and WAC 388-71-0726]

The ADH center must refer the client to a local Medical Assistance Administration (MAA) transportation broker when the client needs transportation to or from the ADH center. The broker may consult with the client's physician, family, case manager, or ADH center as needed in making any transportation arrangements. Refer to MAA's Transportation web site for further information: http://maa.dshs.wa.gov/Transportation/index.html .

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Fee Schedule

Use the following HCPCS* codes, as appropriate, when billing for Adult Day Health (ADH) services. Send your HCFA-1500 claim forms to the MAA address listed in the Important Contacts section.

☞ **Note:** The reimbursement rates for ADH services are determined according to the county where the provider is located, not by the client's county of residence. MAA reimburses ADH services based on a daily rate (four hour day).

Procedure Code	Modifier	Description	7/1/05 Maximum Allowable
T1023	HT	**Screening to determine the appropriateness for consideration of an individual for participation in a specified program** Use for: Adult Day Health intake evaluation	$90.27
S5102	TG	**Day health services, adult, per day.** King County	$47.96
S5102	TG	**Day health services, adult, per day.** Benton, Clark, Franklin, Island, Kitsap, Pierce, Snohomish, Spokane, Thurston, Whatcom, and Yakima	$43.49
S5102	TG	**Day health services, adult, per day.** Other counties	$41.09

☞ **Note:** The maximum allowable amounts listed above are predetermined and do not include transportation. Transportation to and from the program site is not reimbursed under the ADH rate. Arrangements for transportation for eligible MAA clients are made with local MAA transportation brokers, informal providers, or other available resources per Chapter 388-546 WAC.

Key to Modifiers:

HT = Multi-disciplinary team
TG = Complex/high tech level of care

*HCPCS stands for the Healthcare Common Procedure Coding System

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Billing

What is the time limit for billing?

- MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has three timeliness standards: 1) for initial claims; 2) for resubmitted claims, other than prescription drug claims; and 3) for resubmitted prescription drug claims.

- The provider must submit claims as described in MAA's billing instructions.

- MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders MAA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed certification[1] criteria.

- MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - ✓ DSHS certification of a client for a retroactive[2] period; or
  - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

- MAA requires providers to bill known third parties for services. [See WAC 388-501-0200 for exceptions.] Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

[1] **Delayed Certification:** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month – If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible form the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

[2] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found to be eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for the service.

- Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  Note: MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee.

How do I bill for services provided to primary care case management (PCCM) clients?

When billing for services provided to primary care case management (PCCM) clients:

- Enter the referring PCP or PCCM name in field 17 on the HCFA-1500 claim form; and
- Enter the seven-digit identification number of the PCCM who referred the client for the services(s). If the client is enrolled in a PCCM plan and the PCCM referral number is not in field 17a when you bill MAA, the claim will be denied.

To find referral numbers, visit the following web site: http://maa.dshs.wa.gov/PNR/Login.aspx

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's Medical Identification card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA *Remittance and Status Report or Health Care Payment and Remittance Advice* for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement or EOB;
- If rebilling, also attach a copy of the MAA *Remittance and Status Report* showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on MAA's website at http://maa.dshs.wa.gov/LTPR/ or may be obtained by calling the Coordination of Benefits Section at 1 (800) 562-6136 (toll free).

What must I keep in a client's file?

Specific to Adult Day Health (ADH)

[Refer to WAC 388-71-0744 and WAC 388-71-0746]

The ADH center must have policies and procedures to ensure that the client's record/chart is appropriately organized and that confidentiality of information is maintained.

Client information forms must be standardized, with each page showing the client's name or identification number.

Individual client files must include:

- Personal/biographical data, including addresses, phone numbers, emergency contacts, and client representatives, reviewed and updated as needed;
- Application, enrollment, and consent to services forms;
- Department-authorized service plan and service authorization;
- All client information, including but not limited to the intake evaluation, negotiated care plan, attendance and service records, progress notes, and correspondence;
- Signed authorizations concerning the release of client information, photographs, and receipt of emergency medical care, as appropriate;
- Client photograph, with client or client representative permission, updated as needed;
- Transportation plans;
- Fee determination forms;
- Appropriate medical information, with client consent, including but not limited to significant illnesses, accidents, treatments, medical conditions, immunizations, allergies, medications, tobacco use, and alcohol or substance use;
- Advance directives (if any) and a statement signed by the client that he or she has received the center's policies concerning advance directives; and, as applicable,
- Physician orders for skilled nursing and/or rehabilitative therapy containing department-required information and in accordance with applicable licensing and practice act regulations.

1. Entries in the client's record must be typewritten or legibly written in ink, dated, and signed by the recording person with his/her title. Identification of the author may be a signature, initials, or other unique identifier within the requirements of applicable licensing standards and center policy.

2. Progress notes must be chronological, timely, and recorded at least weekly by ADH centers. Client dates of attendance are to be kept daily.

3. Consultation and/or care plan reviews must be dated and initialed by the physician or other authorizing practitioner who reviewed them. If the reports are presented electronically, there must be representation of review by the ordering practitioner.

4. Documentation of medication use must include the name of the medication, dosage, route of administration, site of injection if applicable, and signature or initials of the person administering the medication, title, and date.

5. The record must be legible to someone other than the writer.

6. Department-contracted ADH centers must comply with all other applicable documentation requirements under WAC 388-502-0020.

General for all providers

[Refer to WAC 388-502-0020]

Enrolled providers must keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

1. Date(s) of service;
2. Patient's name and date of birth;
3. Name and title of person performing the service, if other than the billing practitioner;
4. Chief complaint or reason for each visit;
5. Pertinent medical history;
6. Pertinent findings on examination;
7. Medications, equipment, and/or supplies prescribed or provided;
8. Description of treatment (when applicable);
9. Recommendations for additional treatments, procedures, or consultations;
10. X-rays, tests, and results;
11. Plan of treatment and/or care, and outcome; and
12. Specific claims and payments received for services.

Charts/records must be available to DSHS, its contractors, and to the U.S. Department of Health and Human Services upon request, for six years from the date of service or longer if required specifically by federal or state law or regulation. DSHS conducts provider audits in order to determine compliance with the various rules governing its medical programs. Being selected for an audit does not necessarily mean that your business has been predetermined to have faulty business practices.

Note: A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. [Refer to WAC 388-502-0020(2)]

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How to Complete the HCFA-1500 Claim Form

Important!

Guidelines/Instructions:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferable on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, or laser-printer generated) HCFA 1500 claim forms.

- **Do not use red ink pens (use black ink for the circle "XO" on crossover claims), highlighters, "post-it notes," or stickers** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," OR "SECOND SUBMISSION" on the claim form.

- **Use standard typewritten fonts** that are 10 c.p.i. (characters per inch). Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink is not too light or faded.**

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form.** MAA does not accept "continued" claim forms. If more than six detail lines are needed, used additional claim forms.

- **Show the total amount for each claim form separately.** Do not indicate the entire total (for all claims) on the last claim form; **total each claim form.**

Field Description

1a. **Insured's ID No.**: Required. Enter the Patient Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the DSHS Medical ID card consisting of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
- John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the Medicaid client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or program name (e.g., the insured's health maintenance organization, private supplementary

insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, and Medicare, etc., are ***inappropriate*** entries for this field.

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medical Assistance pays as payer of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d.** is left blank, the claim may be processed and denied in error.

17. **Name of Referring Physician or Other Source**: When applicable, enter the primary physician.

17a. **ID Number of Referring Physician**: When applicable, enter the 7-digit MAA-assigned primary physician number. See http://maa.dshs.wa.gov/PNR/Login.aspx

19. When applicable. If the client has no Part A coverage, enter the statement "Client has Medicare Part B coverage only" in this field.

21. **Diagnosis or Nature of Illness or Injury**: Enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the *Remittance and Status Report*.)

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 03, 2004 = 100304).

24B. **Place of Service**: Required. This is the only appropriate code for Washington State Medicaid:

Code Number	To Be Used For
99	Other

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) procedure code for the services being billed.

Modifier: When appropriate enter a modifier.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM current volume.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

24G. **Days or Units**: Required. Enter the total number of days or units (up to 999) for each line. These figures must be whole units.

25. **Federal Tax ID Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your *Remittance and Status Report* under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code And Phone #**: Required. Put the *Name, Address,* and *Phone #* on all claim forms.

P.I.N.: This is the seven-digit number assigned to you by MAA for:

A) An individual practitioner (solo practice); **or**
B) An identification number for individuals only when they are part of a group practice (see below).

Group: This is the seven-digit number assigned by MAA to a provider group that identifies the entity (e.g., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made under this number. NOTE: Certain group numbers may require a PIN number, in addition to the group number, in order to identify the performing provider.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

Adult Day Health

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): PJ090824LONG B

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LONG, PETE J.

3. PATIENT'S BIRTH DATE MM DD YY: 09 08 24 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 62 SOUTH STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V95.0 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 04 15 00	04 15 00	9	9	0801H		V95.0	8456	1				
2 04 16 00	04 16 00	9	9	0803H		V95.0	4492	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. $ TOTAL CHARGE: 12948

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 12948

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

DAYHEALTH 206-391-6888
1500 PINE
ANYTOWN WA 98000

PIN# 9012345 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500